Clinical Section.

President—Sir HERBERT WATERHOUSE, F.R.C.S.

CASES.

Chronic Renal Disease with Bony Changes.

By A. A. OSMAN, M.R.C.P.Lond.

H. P., AGED 12. First complained of weakness of legs 5 to 6 years ago. Attended Out-Patients' Department August 25, 1926. Thin, pale, and undersized, with marked genu valgum.

Urine then contained albumin, 1 part per 1,000, a good trace of sugar, a few red cells, and epithelial cells in the urine, but no casts. Later, a few hyaline casts were observed.

Heart and arteries normal. Systolic blood-pressure normal, = 90 mm. Hg. Retinæ normal. Wassermann reaction negative.

Blood-count: red blood-cells, 4,112,000; white blood-cells, 8,000; Hb. 70 per cent.; colour index, 0·9; polymorphonuclears 58 per cent., lymphocytes 38 per cent., eosinophils 4 per cent.; plasma $NaHCO_3$, 0·025 (normal 0·032 molar); blood urea, 21 mgm. per 100 c.c.; blood calcium, 10 mgm. per 100 c.c.

Urea concentration:—

	VOL.		C.C.N.		
First hour	52 c.c.	...	40·2 c.c.	...	2·51 per cent. urea
Second ,,	40 c.c.	...	60·2 c.c.	...	3·76 ,, ,,
Third ,,	36 c.c.	...	60·5 c.c.	...	3·78 ,, ,,

Repeated examinations of the urine for tubercle bacilli proved negative. There were no signs of tuberculosis in the chest that could be detected clinically or by X-ray. Radiograms of the kidney regions showed shadows suggesting calcified glands in the region of the left kidney. A pyelograph by Mr. J. Alban Andrews showed that these shadows were not in the kidney. The temperature charts shown suggest tuberculosis.

After some weeks' treatment with alkalies the albuminuria and glycosuria disappeared. The X-ray appearances of the bones are not typical of renal dwarfism, or late rickets. The case is shown for opinions as to the possible connexion, if any, between the bony and renal lesions.

Case for Diagnosis.

By A. A. OSMAN, M.R.C.P.Lond.

V. L., AGED 3½. An only child, born at full-time, thirteen years after the only other pregnancy, which resulted in a miscarriage. Breast-fed for one year and three months. At this age attended Out-Patients' Department, for diarrhœa of a few days'

duration. Child pale and thin, but not very ill. There was a bilateral, symmetrical swelling of the malar bones and slight beading of the ribs. No other signs of rickets. Up to this date patient's development had been normal. Wassermann reaction negative in both mother and child. Patient has attended Out-Patients' Department since at regular intervals, and during this time the bony swelling over the left malar region has slowly increased in size, causing a slight but definite proptosis of the left eye. The swelling over the right malar region has not increased in size, and possibly it is even smaller than when first seen. X-ray examination of the skull gives no information as to the nature of the swelling. The urine contains no abnormal constituents.

Dr. F. PARKES WEBER thought the bony swelling on the left side of the skull was allied to what was formerly called leontiasis ossea, and was due to a condition of osteitis fibrosa.

Three Cases of Arthroplasty for Ankylosis of the Temporo-Mandibular Joint.

By E. C. HUGHES, O.B.E., M.Ch.

Case I.—W. R., male, aged 10. In May, 1921, the right side of his face became swollen and two teeth were extracted. The swelling did not subside, and in the following August an incision was made on the inner side of his cheek and non-purulent serous fluid evacuated. A month later two lower milk molars were extracted and both the external and internal alveolar margins were found to be necrosed. They were removed. After that there was very little discharge, but there was a continuous offensive smell. Later, the right side of the face again became swollen from bony overgrowth of the mandible.

In June, 1922, a sequestrum was removed. In October of the same year he was again admitted for disability of mastication. Another sequestrum was removed. The lower jaw was then slightly deviated to the right, and the left side was not well developed. In December of the same year the articular process of the lower jaw on the right side became loose and was removed.

In June, 1926, he was re-admitted into hospital for ankylosis of the right temporo-mandibular joint. The new bone, condyle, and coronoid process were removed.

Case II.—D. W., female, aged 11. Fixation and immobility of the lower jaw noticed by the mother three weeks after birth. There was no history of accident.

Patient admitted to Guy's Hospital at the age of 4 in June, 1919, when it was noticed that she had no chin, but enlargement and bulging of the right cheek with flatness of the left. The mandible was deviated towards the right. The lower teeth sloped backwards, and between the upper and lower rows there was an interval of about ½ in. There was absolute fixation of the lower jaw; patient had never eaten any solid food and her power of speech was very poor.

The right joint was then operated upon and the neck of the mandible was found to be short and thick. It expanded into the condyle without the definite thinning occurring normally. The condyle was flattened rather than rounded. Between it and the fossa no trace of the articular cartilage was found, but there was a dense band of fibrous tissue. This was removed, together with the condyle and part of the neck. A strip of temporal fascia was then inserted between the fossa and the stump of the neck of the mandible. A week later the left side was opened, but the joint was found to be normal.

Case III.—R. M., male, aged 18. Patient said he was knocked over by a bicycle